U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 03 January 2005

In the Matter of:

BRICE SHUMATE,
Claimant,

CASE NO. 2003-BLA-6252

v.

FALCON ENERGY, INC.,
Employer,

and

WEST VIRGINIA COAL WORKERS' PNEUMOCONIOSIS FUND,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Frederick K. Muth, Esquire
For the Claimant

Robert Weinberger, Esquire
For the Employer/Carrier

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER-AWARDING BENEFITS

Statement of the Case

This proceeding arises from a claim for benefits filed by Brice Shumate, a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal

Regulations.[1] Because the Claimant was last employed in the coal mine industry in West Virginia, the law of the United States Court of Appeals for the Fourth Circuit controls. *See Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989) (en banc).

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of coal mine dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by coal workers' pneumoconiosis, commonly known as black lung.

On June 20, 2001, Claimant, Brice Shumate, filed the current application for black lung benefits under the Act (DX 2). On April 11, 2003, the District Director issued a Proposed Decision and Order awarding benefits (DX 31).[2] Following Employer's timely request for a formal hearing (DX 33), the claim was referred to the Office of Administrative Law Judges for adjudication (DX 37-39). A formal hearing was held on December 16, 2003, in Princeton, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and regulations.[3] The findings of fact and conclusions of law which follow are based upon an analysis of the entire record, including the testimony, documentary evidence, and arguments, and reflect pertinent, credibility determinations concerning the evidence.

Issues

I. Whether Claimant has pneumoconiosis as defined by the Act and the regulations.
II. Whether Claimant's pneumoconiosis, if proved, arose out of coal mine employment?
III. Whether Claimant is totally disabled?
IV. Whether Claimant's total disability, if proved, is due to pneumoconiosis?

(DX 37; TR 7).[4]

Findings of Fact

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on June 20, 2001 (DX 2), the new regulations are applicable (DX 39). All references by part or section are to regulations in Title 20, Code of Federal Regulations, unless otherwise indicated.

[2] At the formal hearing, an erroneous recitation that this claim was not in pay status was not disputed. The record reflects no payment by the Black Lung disability Trust Fund (DX 37). (TR 7). In fact, however, the District Director awarded benefits, and Employer has been paying benefits "under protest" (DX 36,37).

[3] The record includes the hearing transcript, citations to which are denoted "TR"; Director's Exhibits 1 through 39 (DX 1-39) and Claimant's Exhibits 1, 2A, and 2B (CX 1, 2A, 2B). In addition, the briefs of the respective parties have been received and considered.

[4] At the formal hearing, Employer withdrew "dependency" as a contested issue (TR 7).

Background

Coal Miner and Length of Coal Mine Employment

The parties stipulated, and the record supports a finding, that Claimant engaged in coal mine employment for 23 years (TR 7,14).

Responsible Operator

Employer, Falcon Energy, Inc., concedes that it is the properly designated responsible operator in this case, under Subpart G, Part 725 of the regulations (DX 3-6,37; TR 14).

Personal, Employment, and Smoking History

Claimant was born on March 25, 1951. He has one dependent, his spouse, Rhonda Shumate (nee Jones) for the purpose of augmentation of benefits under the Act. (DX 2,11; TR 7,11). Claimant's last usual coal mine employment was as a section foreman. In that capacity, he supervised the production of a crew of men in underground mining. Claimant testified that the job was not simply supervisory, and that the crew was shorthanded, so that his job entailed heavy exertion, such as "pulling cables, rock dusting, shoveling, relieving out on equipment, hanging ventilation." (TR 14-15).

Claimant stopped working as a miner in October 1998, when he tore the ACL in his right knee (DX 2; TR 14,19). However, Claimant testified that his breathing problem was becoming so severe that he did not believe he could have continued, even without the knee injury. Claimant noted that he had been hospitalized for a week prior to the injury for his breathing condition (TR 19). Claimant testified that he first noticed his breathing problems in 1996, and that his condition has worsened (TR 16). He has been treated for the past five years for his breathing problems with a nebulizer, inhalers, and pills. Claimant testified that he had been hospitalized seven times between 1996 and April 2003 due to his breathing condition, and that he feels that his breathing problem alone would prevent him from performing his coal mine work (TR 17-18). Claimant also takes medication for high blood pressure, which had no effect on his ability to do his last coal mine job (TR 21). Notwithstanding his breathing condition and knee injury, Claimant still does some household chores, such as using a push mower (TR 20).

Claimant testified that when he stopped working as a coal miner, he only weighed 240 pounds, but has gained more than 80 pounds, is six feet tall, and currently weighs 322 pounds. (TR 12, 20-21). He testified that his claim for state black lung benefits was denied by the West Virginia Occupational Pneumoconiosis Board the previous year (TR 13).[5]

Regarding his smoking history Claimant gave the following answers on cross-examination:

[5] The denial of West Virginia occupational pneumoconiosis benefits has little probative significance, since the underlying statutes, regulations, and evidence are distinguishable from those which determine this Federal black lung claim.

Q Mr. Shumate, did you ever smoke cigarettes, Sir?
A Yes.
Q Can you tell me approximately when you started smoking?
A 1972.
Q And when did you - - are you still smoking now?
A No.
Q Can you tell me when you stopped smoking, Sir?
A 1998.
Q And during the approximately 16 (sic) years that you were smoking, how much did you smoke?
A A pack, pack and a half a day.

(TR 18-19).

Claimant thus testified that he smoked approximately 1-1 ½ packs per day from 1972 to 1998, a total of 26 years (TR 18-19). However, the medical reports and deposition testimony of record all indicate that Claimant actually stopped smoking cigarettes in 1988, *not* 1998, which suggests a misunderstanding or misstatement or erroneous transcription of his testimony (DX 13,21; CX 1, p. 8; CX 2A; CX 2B). Consequently, the record as a whole supports a smoking history of about 1-1 ½ packs per day for 16 years ending in 1988.

Medical Evidence

Chest X-rays

The record contains x-ray interpretations of films dated February 25, 2002 (DX 18,19,20), November 27, 2002 (DX 21), and June 11, 2003 (CX 2A). The following were interpreted as positive for simple pneumoconiosis under the classification requirements set forth in § 718.102(b): Dr. Patel's (1/1) reading of the February 25, 2002 x-ray (DX 18) and Dr. Robinette's (1/0) interpretation of the June 11, 2003 film (CX 2). The following were negative readings: the "completely negative" interpretations by Drs. Wiot (DX 20) and Zaldivar (DX 21) of the chest x-rays, dated February 25, 2002 and November 27, 2002, respectively.[6] All of the physicians are B-readers. Drs. Patel and Wiot are dually-qualified B-readers and board-certified radiologists. The conflicting interpretations by similarly qualified B-readers and/or board-certified radiologists do not establish the presence of pneumoconiosis. Accordingly, Claimant has not established the presence of pneumoconiosis by a preponderance of the x-ray evidence.

Pulmonary Function Studies

A claimant must prove that he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. Regulatory criteria for determining the existence of total disability

[6] Dr. Binns, a B-reader and Board-certified radiologist, read the February 25, 2002 chest x-ray for film quality only as "2" (*i.e.,* "Acceptable with no technical defects likely to impair classification of the radiograph for pneumoconiosis"). (DX 19). An x-ray interpretation by Dr. McReynolds of the film dated June 11, 2003 (CX 2) exceeds the applicable evidentiary limitations, was not cited by either party, and would not be outcome determinative in any event.

include the results of pulmonary function studies and arterial blood gas studies. The record includes pulmonary function studies performed by Claimant on February 25, 2002 (DX 17), November 27, 2002 (DX 21), and June 11, 2003 (CX 2A). None of the test results are qualifying under the regulatory criteria set forth in Part 718, Appendix B. Therefore, total disability is not established on the basis of the pulmonary function evidence.

Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange which will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The record includes arterial blood gas studies which were administered on February 25, 2002 (DX 14), November 27, 2002 (DX 21), and June 11, 2003 (CX 2A).

The February 25, 2002 blood gases, at rest and exercise, are both qualifying under the applicable standards stated in Part 718, Appendix C (DX 14), and were found to be technically acceptable upon review by Dr. Gaziano, who is board-certified in Internal Medicine, Chest Diseases, and Critical Care Medicine (DX 15,16). The arterial blood gas studies dated November 27, 2002, are nonqualifying at rest, but qualifying with exercise (DX 21). The blood gas test, dated June 11, 2003, was only administered at rest. The results were slightly above the qualifying values (CX 2A).

Because the resting blood gas results are inconclusive, but the exercise blood gas results are clearly qualifying, and Claimant's usual coal mine employment entailed considerable manual labor, the exercise blood gas studies are more probative, and total disability is established on the basis of the arterial blood gas evidence.

Physicians' Opinions

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. § 718.202(a)(4). Where total disability cannot be established, under § 718.204(b)(2)(i), (ii), or (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b)(2)(iv).

Dr. Rasmussen

Dr. Donald L. Rasmussen, a B-reader board-certified in Internal Medicine, examined Claimant on May 31, 2002 (DX 13). Dr. Rasmussen is not board-certified in Pulmonary Medicine, but had pulmonary training and has practiced pulmonary medicine relating to coal worker's pneumoconiosis since 1962. Dr. Rasmussen estimated that he has given complete pulmonary evaluations to "approximately 50,000 or more" coal miners (CX 1, pp. 5-6). He prepared a medical report on June 28, 2002 (DX 13) and a U.S. Department of Labor medical

examination form dated July 8, 2002 (DX 13) which record Claimant's complaints of worsening shortness of breath since 1996, past medical history, medications, family history, an occupational history of about 27 years between 1972 and 1998, and a cigarette smoking history of 1 ¼ packs per day from 1971 until 1988. Physical findings on examination included moderately reduced breath sounds, but no pulmonary rales, rhonchi or wheezes. Dr. Rasmussen recorded the results of clinical tests as follows:

Chest X-ray	Pneumoconiosis t/q 1/1 all zones, bilateral pleural thickening.
Vent Study (PFS)	Normal.
Arterial Blood Gas	Marked impairment in oxygen transfer with minimal exertion.
Other:	SBDLCO is minimally reduced

(DX 13, Sec. D5).

Citing Claimant's "marked impairment in oxygen transfer and marked hypoxia," Dr. Rasmussen opined:

> The patient exhibits poor exercise tolerance, and marked loss of lung function. He does not retain the pulmonary capacity to perform his last regular coal mine job.
>
> The two risk factors are his cigarette smoking and his coal mine dust exposure. (His resting hypoxia was probably secondary to his obesity). His coal mine dust exposure is considered more significant than his cigarette smoking judging by his marked impairment in oxygen transfer during exercise absent ventilatory impairment.

(DX 13).

In his deposition testimony on August 25, 2003 (CX 1), Dr. Rasmussen acknowledged that Claimant had enough of a cigarette smoking history to induce disease in a susceptible individual (CX 1, p. 8). He also noted that Claimant had essentially normal pulmonary function results despite being borderline morbidly obese (CX 1, p. 9). In addition, Dr. Rasmussen stated that Dr. Zaldivar is probably correct in finding sleep apnea, which Dr. Rasmussen related to Claimant's obesity, which could also cause resting hypoxia, but *not* exercise-induced hypoxemia (CX 1, pp. 10-11). Dr. Rasmussen discounted Claimant's cigarette smoking history as a cause of lung disease in this case because of the absence of any significant airway obstruction (EX 1, p. 8). Dr. Rasmussen questioned Dr. Zaldivar's alternative diagnosis of idiopathic pulmonary fibrosis, noting that such a diagnosis usually is associated with a reduction in FVC and total lung capacity, which is not found in Claimant's case. Dr. Rasmussen testified that the absence of end-inspiratory crackles on examination also favors the diagnosis of coal worker's pneumoconiosis over pulmonary fibrosis (CX 1, pp. 11-12). Therefore, despite the negative x-ray readings by Drs. Zaldivar and Wiot, Dr. Rasmussen's review of the available evidence, led him to conclude that Claimant suffers from coal worker's pneumoconiosis and that pneumoconiosis is the major cause of his totally disabling pulmonary or respiratory impairment (CX 1, pp. 13-14).

On cross examination, Dr. Rasmussen testified that resting blood gas studies are so variable and unpredictable that you can't make any assumptions regarding changes in such tests.

He explained that the change in the exercise blood gases, in this case from pO_2 58 to 68, between February and November 2002 were due to the different levels of exercise, and did not indicate a significant difference in oxygen consumption, as demonstrated by the a/a gradient results. Accordingly, Dr. Rasmussen declared that Dr. Zaldivar's exercise blood gas results obtained in November are quite consistent with those which he, Dr. Rasmussen, had obtained in February 2002, approximately nine months earlier, because of normal variations, variations in test positions, variations in the amount of exercise, and Claimant's significant weight gain. Dr. Rasmussen opined that "there's nothing, whatsoever, to indicate that Dr. Zaldivar's blood gas studies are less abnormal than our own when you compare the exercise level." (CX 1, pp. 14-18).

Dr. Zaldivar

Dr. George L. Zaldivar, a B-reader who is board-certified in Pulmonary Disease, Internal Medicine, Sleep Disorder, and Critical Care Medicine (DX 21), examined Claimant on November 27, 2002. In a "History & Physical Examination" report on that date (DX 21), Dr. Zaldivar set forth Claimant's chief complaint of shortness of breath. He reported shortness of breath, as well as wheezes, cough, and gasping when Claimant walks up one flight of stairs, difficulty sleeping, and medication for high blood pressure. He noted Claimant's past medical history, which included a smoking history of 1 to 1 ½ packs per day beginning at age 20 and ending in 1988. Dr. Zaldivar recorded that Claimant worked as a coal miner for 23 ½ years ending in 1998, as well as Claimant's personal and social histories, family and personal illnesses, and the review of systems, as well as physical findings on examination. In pertinent part, Dr. Zaldivar observed: "LUNGS: Clear to auscultation. On forced exhalation, wheezes were heart (sic) at the level of the trachea and vocal cords. He was breathing very deeply and appeared to be hyperventilating during most of the interview." In summary, Dr. Zaldivar concluded:

IMPRESSION:

1. History consistent with obstructive sleep apnea due to obesity.
2. Either vocal cord dysfunction producing wheezing, or asthma.
3. Normal examination of the lungs with wheezing originating apparently at the vocal cord level.
4. History of arthritis.

(DX 21).

In a supplemental report dated December 23, 2002 (DX 21), Dr. Zaldivar reviewed and analyzed his own examination, including laboratory data which he obtained, in conjunction with his review of Dr. Rasmussen's examination and clinical test results performed on February 25, 2002. He recorded:

FINDINGS

My own findings are as follows:

1. Summary of the history and physical examination as listed under "Impression."
2. No radiographic evidence of pneumoconiosis.
3. Moderate exercise impairment due to hypoxemia which is causing a drop in the pO_2 during exercise.
4. Subtherapeutic Theophylline level.
5. Low carboxyhemoglobin of a current nonsmoker.
6. Normal spirometry.
7. Normal lung volumes.

COMMENTS

The information which you sent me, plus the information obtained in my office, shows that Mr. Shumate's wheezing appears to originate in the area of the trachea. In my opinion, what he has is not asthma, but, rather, vocal cord dysfunction which is causing the wheezes. His breathing capacity has been normal on the two occasions in which he has been tested. The Diffusing Capacity, however, is low which is in keeping with drop in the pO_2 with exercise. An isolated impairment of diffusion is absolutely unrelated to the occupation of a coal miner and dust exposure.

The low diffusion means that pulmonary fibrosis is developing which, judging by the smoking habit, may well be the result of pulmonary fibrosis or bronchiolitis resulting from the smoking. Whatever the cause of the low Diffusion Capacity, coal worker's pneumoconiosis is not one of them.

OPINIONS

Taking all of this information into consideration, my answers to your questions are as follows:

1. There is no evidence in this case to justify a diagnosis of coal worker's pneumoconiosis nor any dust disease in the lungs.

2. There is a pulmonary impairment present which is manifested by a low Diffusing Capacity and drop in the pO_2 with exercise, both of which are manifestations of pulmonary fibrosis which might be related to his smoking habit or may be idiopathic.

3. Even if Mr. Shumate were found to have coal worker's pneumoconiosis, which in my opinion he does not have, coal worker's pneumoconiosis does not result in a reduction of the Diffusing Capacity in the absence of airway obstruction, nor does it cause daytime drowsiness, which in this case is the result of obstructive sleep

apnea. Therefore, my opinion regarding the cause of the pulmonary impairment and the extent of the impairment would remain the same as I have given here.

(DX 21).

Dr. Robinette

Dr. Emory H. Robinette, a B-reader, who is board-certified in Internal Medicine and Pulmonary Disease, examined Claimant on June 11, 2003. In a report, dated July 7, 2003 (CX 2A), Dr. Robinette set forth an occupational history of 23 ¼ years ending in October 1998, and a somewhat understated cigarette smoking history of approximately 15 pack years beginning at age 21 and ending in 1988. Dr. Robinette also reported Claimant's complaints, symptoms, medical history, family history, review of systems, and findings on physical examination. In addition, Dr. Robinette summarized the results of various clinical tests performed in connection with his examination, including chest x-ray, pulmonary function studies, resting arterial gases, and an EKG. Based upon the foregoing, Dr. Robinette opined:

IMPRESSION:

1. Simple coal workers' pneumoconiosis with a profusion abnormality of 1/0, predominant Q/P opacities with nonspecific pleural thickening along the right lateral chest wall.
2. Mild hypoxemia with a reduction of the diffusion capacity compatible with interstitial pulmonary fibrosis.

3. Hypertensive cardiovascular disease.

4. Obesity.

(CX 2A). Dr. Robinette also reviewed and analyzed medical records by Drs. Zaldivar and Rasmussen, including their clinical test results. He opined:

> In conclusion there is evidence of a mild to moderate respiratory impairment based on the reduction of the diffusion capacity with demonstrated excise (sic) intolerance, evidence of exercise induced hypoxemia.
>
> It is my impression that Mr. Shumate does have an occupational pneumoconiosis which occurred as a direct consequence of his coal mining employment. He additionally has the physical stigmata associated with obstructive sleep apnea and needs an outpatient polysomnography study.

(CX 2A).

In a supplemental report, dated September 19, 2003 (CX 2B), Dr. Robinette reviewed and analyzed the medical evidence and cited medical literature, responsive to an inquiry by Claimant's counsel, concluding in pertinent part:

> Clearly, the available literature concerning diagnostic testing of individuals with coal workers' pneumoconiosis acknowledges that pulmonary function studies are often very variable on the population because of the different population group study. Hurley and Sutare in the *British Journal of Industrial Medicines 1986* did a long-term follow-up of coal miners who did not have progressive massive fibrosis but were felt to have suffered a greater than average affect of dust exposure found that there is a specific relationship between FEV_1 in some miners and even moderate dust exposure. Nemhery & Associates reviewing the Impairment of Ventilatory Function and Pulmonary Gas Exchange in Nonsmoking Coal Miners in the *Lancet 1987* additionally examined a group of individuals who were found to have normal x-rays and demonstrated marked deterioration in the FEV_1. Several investigators including Dr. Morgan published in *JAMA 1975*, Dr. Lyons & Associates in 1967, and Dr. Rasmussen in the *American Review of Respiratory Disease 1970* demonstrated that the reduced diffusion opacity (sic) and impaired gas exchange occurs in individuals who have micronodular or P type opacities are more common. Writer & Associates additionally demonstrated that patients with emphysema may additionally have gas exchange abnormalities.
>
> Clearly, Mr. Shumate had substantial dust exposure which would account for the radiographic abnormalities as described by our official B reader interpretation. It is my medical impression based on the diagnostic studies submitted to me from Dr. Rasmussen's office, my physical examination and the patient's clinical history that he clearly has significant respiratory dysfunction which would prohibit [him] from working as an underground coal miner. This is based on the fact that he has evidence of reduction of his diffusion capacity, resting hypoxemia and has demonstrated oxygen desaturation with exercise with abnormal exercise test. This condition is chronic and irreversible and is significantly related to his dust reticulation and exposure as documented within the body of my record. The literature supports that the pneumoconiosis is a contributing factor to his respiratory impairment as described by the literature citation within the body of this report.

(CX 2B).

Discussion and Applicable Law

Pneumoconiosis

Section 718.202 provides four means by which coal workers' pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. A preponderance of the chest x-ray evidence of record does not establish the presence of pneumoconiosis under §718.202(a)(1). Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case §718.304 does not apply because there is no evidence of complicated pneumoconiosis; § 718.305 does not apply to claims filed after January 1, 1982; and

§718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." § 718.202(a)(1) and (2). Though Dr. Rasmussen is not board-certified in pulmonary medicine, he has extensive pertinent experience with miners and coal workers' pneumoconiosis. Consequently, the three physicians are recognized as pulmonary specialists, and the relative qualifications of the physicians are not deemed to be a significant factor in weighing their relative credibility.

Drs. Rasmussen and Robinette both found that Claimant has pneumoconiosis arising from his coal mine dust exposure; a disabling pulmonary or respiratory impairment which would prevent him from performing his last usual coal mine work; and that this totally disabling condition is largely attributable to coal workers' pneumoconiosis (DX 13; CX 1, 2A, 2B), Dr. Zaldivar agreed that Claimant suffers from a pulmonary impairment, which is manifested by a low diffusion capacity and a drop in the pO_2 on the exercise blood gases, and opined that Claimant suffers from "a disability not only from the breathing standpoint, judging by the blood gases, but also from the standpoint of obesity." (DX 21) Dr. Zaldivar's conclusion is not inconsistent with that of Drs. Rasmussen and Robinette that Claimant cannot perform his last usual coal mine job from a pulmonary or respiratory standpoint.[7] However, Dr. Zaldivar found "no evidence to justify a diagnosis of coal worker's pneumoconiosis nor any dust disease of the lungs," and attributed Claimant's pulmonary impairment to pulmonary fibrosis related to either smoking or to an idiopathic etiology.

Since the x-ray evidence is inconclusive, and none of the physicians relied exclusively or even primarily upon the x-ray evidence in reaching their conclusions, their reliance upon different assessments of that evidence does not significantly affect the credibility of their conclusions. Drs. Rasmussen and Robinette relied upon positive x-ray interpretations; Dr. Zaldivar relied upon a negative x-ray interpretation. All three physicians discussed other medical data and reached various opinions regarding the results of pulmonary function testing, diffusion capacity, and exercise blood gases, and their consistency or inconsistency with pneumoconiosis and/or coal mine dust-induced impairment.

Drs. Rasmussen and Robinette are more convincing than Dr. Zaldivar's regarding the "pneumoconiosis," "causal relationship," and "causation" issues, because their analyses are deemed to be better reasoned and documented, and less equivocal than Dr. Zaldivar's. Dr. Zaldivar attributed Claimant's disability to "pulmonary fibrosis," while reporting "completely negative" x-ray findings, but was equivocal regarding the etiology of the pulmonary fibrosis, stating that it "might be related to [Claimant's] smoking habit or may be idiopathic." Idiopathic obviously means of unknown origin, and does not establish an affirmative etiology. Dr.

[7] In Employer/Carrier's Brief, p. 5, counsel acknowledged that "Drs. Rasmussen, Robinette and Zaldivar each concluded that Claimant is totally disabled."

Zaldivar's categorical *ex cathedra* declarations that "an isolated impairment of diffusion is absolutely unrelated to the occupation of a coal miner and dust exposure," and that "[w]hatever the cause of the low Diffusion Capacity, coal workers pneumoconiosis is not one of them," are unsupported by any corroborative authority or rationale. Despite his inability to provide a definitive statement regarding the etiology of the disability-inducing pulmonary fibrosis, Dr. Zaldivar opined that, even if Claimant were found to have simple coal worker's pneumoconiosis, it did not cause Claimant's disability.

On the other hand, Dr. Rasmussen specifically addressed the alternative etiologies cited by Dr. Zaldivar and provided a thorough and plausible analysis for his own contrary opinion. Dr. Robinette's report is well-reasoned and documented, and he cites supporting medical literature described as consistent with his conclusions. Furthermore, the findings of pneumoconiosis and occupationally related disability by Drs. Rasmussen and Robinette are consistent with Claimant's significant coal mine employment history which continued until 1998, and Claimant's complaints of progressive worsening of breathing problems. Consequently, Claimant is deemed to have established pneumoconiosis under § 718.202(a)(4).

All the relevant evidence has been weighed together with respect to whether Claimant has pneumoconiosis under § 718.202(a). Since the x-ray evidence is inconclusive and the more probative medical opinions demonstrate legal pneumoconiosis, the presence of pneumoconiosis has been established under § 718.202(a). *See Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997).

Causal Relationship

Since Claimant has established the presence of pneumoconiosis, he is entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. § 718.203. This presumption has not been rebutted.

Total Disability

To be eligible for benefits, Claimant still must establish that he has a totally disabling pulmonary or respiratory impairment, and that such total disability is due to pneumoconiosis. A claimant can establish total disability by showing that he has a pulmonary or respiratory impairment which, standing alone, prevents him from performing his usual coal mine work, and from engaging in gainful employment in the immediate area of his residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he previously engaged with some regularity over a substantial period of time. § 718.204(b)(1). Where, as here, complicated pneumoconiosis is not in issue, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented him from engaging in his usual coal mine work or comparable employment. § 718.204(b)(2)(i)-(iv).

Because the pulmonary function tests of record are not qualifying under the standards stated in Part 718, Appendix B, Claimant has not established total disability pursuant to § 718.204(b)(2)(i). Although the majority of the resting blood gas studies are nonqualifying, greater weight is accorded to the qualifying, exercise blood gas tests, because they would be more reflective of the heavy manual labor which Claimant was required to perform during his last coal mine employment, and there was a consensus among the opining doctors that there was an impaired diffusion capacity disclosed by the exercise tests. Therefore, Claimant is deemed to have established total disability pursuant to § 718.204(b)(2)(ii). Since there is no evidence which establishes the presence of cor pulmonale with right-sided heart failure, Claimant has not established total disability pursuant § 718.204(b)(2)(iii).

Under § 718.204(b)(2)(iv), total disability may also be found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work. Drs. Rasmussen, Robinette, and Zaldivar all found that Claimant suffers from a pulmonary or respiratory impairment, though they were not agreed as to cause, and, explicitly or implicitly, found that such an impairment would prevent Claimant from performing his last usual coal mine employment with its attendant manual labor, or comparable gainful work. Consequently, Claimant has established total disability under § 718.204(b)(2)(iv).

Total disability established on the basis of the arterial blood gas and medical opinion evidence must nevertheless be weighed together with all of the contrary and probative evidence to determine whether Claimant has established total disability under § 718.204(b). *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986). The x-ray evidence would only be evidence of disease, and would not measure functional impairment in any event. Consistent with the foregoing, despite the nonqualifying pulmonary function studies and some nonqualifying arterial blood gases, the exercise blood gas studies and the medical opinion evidence establish total pulmonary or respiratory disability. Accordingly, Claimant has established total disability on the evidence as a whole under § 718.204(b).

Total Disability Due to Pneumoconiosis

Although Claimant has established that he has pneumoconiosis arising from coal mine work, and that he is totally disabled by his pulmonary or respiratory impairment, he must prove that the total disability is due to pneumoconiosis. § 718.204(c).

Under § 718.204(c)(1), "a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment," that is, pneumoconiosis had a material adverse effect on the miner's respiratory or pulmonary condition, or it materially worsened a totally disabling respiratory or pulmonary condition which was caused by a disease or exposure unrelated to coal mine employment. The cause or causes of the Claimant's total disability must be established by means of a documented and reasoned physician's opinion. § 718.204(c)(2).

In this regard, the opinions of Drs. Rasmussen and Robinette are more persuasive than the opinion of Dr. Zaldivar, because of the relative quality of their reasoning, and because of the consistency of Dr. Rasmussen's and Dr. Robinette's opinions with Claimant's lengthy coal mine employment history. As previously discussed, Dr. Zaldivar was equivocal regarding the etiology of Claimant's impairment. By contrast, Drs. Rasmussen and Robinette considered all possible causes of Claimant's impairment and determined that his history of coal mine employment was the most plausible explanation. Accordingly, the better reasoned medical opinion evidence establishes that Claimant's total disability is substantially related to his occupational coal dust exposure and pneumoconiosis. Consequently, Claimant has established total disability due to pneumoconiosis under § 718.204(c). Since Claimant has established the presence of simple pneumoconiosis arising from his 23 years of coal mine employment; since he is totally disabled as defined in the Act and regulations; and since pneumoconiosis is a substantial contributing cause of such total disability, Claimant is entitled to benefits under the Act.

Commencement of Entitlement to Benefits

The evidence does not establish the month of onset of total disability due to pneumoconiosis arising out of coal mine employment. Therefore, payment of benefits shall commence as of June 1, 2001, the beginning with the month in which the miner filed his claim. § 725.503(b). The benefits must be appropriately augmented by reason of Claimant's dependent spouse, Rhonda Shumate.

ORDER

The claim of Brice Shumate for benefits under the Black Lung Benefits Act is granted**.** Falcon Energy, Inc. and West Virginia Coal Workers' Pneumoconiosis Fund shall pay to Claimant, Brice Shumate, all benefits to which he is entitled under the Act, augmented by reason of his dependent spouse, Rhonda Shumate, commencing as of June 1, 2001, with appropriate credit for payments made.[8]

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Edward Terhune Miller
Administrative Law Judge

[8] Claimant's counsel may submit an application for an attorney's fee within thirty days of this decision and order pursuant to § 725.365 and § 725.366. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Interested parties may respond or object within ten days following the receipt of such application. The Act prohibits charging an attorney's fee in the absence of an approved application.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.